# EMPLOYEE DENTAL PLANS

State Health Benefits Program

## ELIGIBILITY

The **Employee Dental Plans** are available to full-time State employees, full-time employees of a local employer (county, municipality, school board, etc.) that elects by resolution to provide the Employee Dental Plans to its employees, and the eligible dependents of these employees. The Employee Dental Plans **are not** available to retirees.

New eligible employees may enroll by completing a *NJ Employee Dental Plans Application* during the first 60 days of employment. The application is available from your Human Resources Representative or Benefits Administrator.

If you do not enroll when first eligible, you have the option to enroll during an annual SHBP/SEHBP Open Enrollment Period. Open Enrollment is normally held in the fall, with coverage effective the following January.

If you do not enroll because of *other* dental coverage and you lose that coverage, you can enroll by submitting an application within 60 days of the loss of coverage.

Once enrolled, you and your eligible dependents must remain in the dental plan you elect for a minimum of 12 months before you can change plans or drop coverage. In the event that you wish to change dental plans, you will not be permitted to do so until the Open Enrollment Period following the 12-month period. In addition, no employee or dependent can be covered under more than one dental plan.

**Note:** Duplicate coverage within the Employee Dental Plans is not permitted; an individual may be covered as an employee or as a dependent but not as both an employee and a dependent. Children may only be covered by one parent.

## DENTAL PLAN CHOICES

You have a choice between two types of dental plans:

- A Dental Plan Organization (DPO); or
- The Dental Expense Plan.

### Dental Plan Organizations

The Dental Plan Organizations (DPOs) are companies that contract with a network of providers for dental services. There are several DPOs participating in the Employee Dental Plans from which you may choose. The *Employee Dental Plans Member Handbook* lists the participating DPOs. (see "For More Information" on page 3).

You must use providers who participate with the DPO you select to receive coverage. Be sure you confirm that the dentist or dental facility you select is taking new patients and participates with the SHBP/SEHBP Employee Dental Plans, since DPOs also service other organizations.

When you use a DPO dentist, diagnostic and preventive services are covered in full. Most other eligible expenses require a copayment (see chart on page 4). In addition, orthodontic treatment is covered for both children and adults, subject to a copayment.

If your dentist drops out of the DPO, you must select another dentist from the DPO. If there are none available within 30 miles of your home, or if you move and your DPO cannot provide a dentist within 30 miles of your home, you may change plans immediately.

## Dental Expense Plan

The Dental Expense Plan is a Preferred Provider Organization (PPO) plan administered by Aetna Dental. The plan allows you to choose any licensed dentist for your dental care, however, you will pay less if you use an in-network provider. There is a deductible to satisfy for some services and some services are eligible only up to a limited amount. The annual plan deductible is $50 per person/$100 per family in-network and $75 per person/$150 per family out-of-network. The deductible does not apply to diagnostic, preventive, and orthodontic services. After you satisfy the annual deductible, you are reimbursed a percentage of the reasonable and customary charges or PPO contracted allowance for services that are covered under the plan.

The Dental Expense Plan provides for the following benefits:

- Diagnostic and Preventive services are paid at 100% (in-network) and 90% (out-of-network) of reasonable and customary allowances or PPO contracted allowance with no deductible.
- Basic Services such as fillings and extractions, are paid at 80% (in-network) and 70% (out-of-network) of reasonable and customary allowances or PPO contracted allowance after deductible.
- Major Restorative services, such as crowns, are paid at 65% (in-network) and 55% (out-of-network) of reasonable and customary or PPO contracted allowance allowances after deductible.
- Prosthodontic services for new or replacement dentures are covered at 50% (in-network) and 40% (out-of-network) of reasonable and customary allowances or PPO contracted allowance after deductible. Repairs to existing dentures are covered at 80% (in-network) and 70% (out-of-network) of reasonable and customary allowances or PPO contracted allowance after deductible.
- Periodontics (treatment of gum disease) is covered at 50% (in-network) and 40% (out-of-network) of reasonable and customary allowances or PPO contracted allowance after deductible.
- Orthodontics are available after you have been employed for 10 months (with no deductible), but only for your children under the age of 19. Orthodontic services are reimbursed at 50% (in-network) and 40% (out-of-network) of reasonable and customary allowances or PPO contracted allowance and have a separate $1,000 in-network and $750 out-of-network individual lifetime reimbursement benefit maximum.
- Benefit Maximum per covered individual is $3,000 annually in-network and $2,000 out-of-network for a maximum of $3,000 combined in and out-of-network. This maximum applies to all eligible services except orthodontic, which has a separate $1,000/$750 individual lifetime benefit maximum.

  With the exception of emergency care, if your Dental Expense Plan treatment includes charges that are expected to cost more than $300, it is strongly recommended that your dentist file for predetermination of benefits with Aetna. With advance approval you will know what services are covered and what payments will be made.

When you use an in-network dental provider, you only pay the provider any applicable deductible and the appropriate coinsurance based on the discounted fee, thereby reducing your out-of-pocket cost. In many cases the in-network dental provider will submit the claims directly to Aetna, eliminating the necessity of your filing claim forms. To find an in-network provider call Aetna at 1-877-238-6200.

## PREMIUM COSTS

**For employees of the State,** the premium cost for dental plan coverage is shared between the State and the employee. The amount of your payroll deduction is available from your Human Resources Representative or Benefits Administrator. Dental rates are also posted on the Division's Web site at: *www.state.nj.us/treasury/pensions/health-benefits.shtml*

State employee premiums can be paid on a pre-tax basis through participation in the Premium Option Plan (POP) of Tax$ave — the State's IRC Section 125 program. Participation in the POP is automatic unless you file a form declining participation. The Internal Revenue Service strictly regulates enrollment in the POP and prohibits any benefit changes outside of an open enrollment period or unless a qualifying life event occurs (e.g., loss of other coverage, marriage, divorce, etc.). Fact Sheet #44, *Tax$ave,* explains the POP in more detail.

**For employees of a participating local employer,** the premium cost for dental plan coverage will vary based upon the policies of that employer in regard to health benefit costs and any labor agreements between the employer and the unions representing the employee. Employees of a participating local employer should see their Human Resources Representative or Benefits Administrator for more information.

## CHOOSING A DENTAL PLAN

Your choice of a dental plan is a personal decision. In deciding whether to enroll and which plan to choose, you should consider:

- The nature and amount of your anticipated dental expenses for the next year;
- The covered services provided by the Dental Expense Plan or a DPO;
- The differences in out-of-pocket costs for each type of plan; and
- The degree of flexibility that you may want in selecting a dentist.

  You can use the summary chart on page 4 of this fact sheet to compare benefit levels under each type of dental plan. If you choose a DPO, you must select a dentist who participates with that particular DPO and who can accept you and your dependents as patients.

## FOR MORE INFORMATION

For more information on the Employee Dental Plans or the names and phone numbers for the individual dental plans, see the *Employee Dental Plans Member Handbook*, available over the Internet at: *www.state.nj.us/treasury/pensions/health-benefits.shtml*

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**PLAN COMPARISON** — The following chart provides a summary description of a variety of dental services under the two types of dental plans offered by the Employee Dental Plans. The chart is not complete and does not describe all the benefits, limitations, or conditions associated with coverage under either type of plan. Please refer to the *Employee Dental Plans Member Handbook* for additional details.

| | **Dental Expense Plan** | | **Dental Plan Organization (DPO)** |
|---|---|---|---|
| | In-Network | Out-of-Network | |
| Deductible | $50 per person per calendar year / $100 per family<br>None for diagnostic/preventative and orthodontic services | $75 per person per calendar year / $150 per family<br>None for diagnostic/preventative and orthodontic services | None |
| Coinsurance | Plan pays: 100% Diagnostic and Preventative<br>80% Basic Restorative<br>65% Major Restorative<br>50% Periodontics, Prosthodontics[1] | Plan pays: 90% Diagnostic and Preventative<br>70% Basic Restorative<br>55% Major Restorative<br>40% Periodontics, Prosthodontics[1] | Plan pays 100% (less copayment) 100% Diagnostic and Preventative |
| Copayments | None | None | Varies depending on service |
| Benefits Maximum | $3,000 (Maximum of $3,000 combined in and out-of-network) per member annually (excluding orthodontics)<br>$1,000 (lifetime) per child for orthodontics | $2,000 (Maximum of $3,000 combined in and out-of-network) per member annually (excluding orthodontics)<br>$750 (lifetime) per child for orthodontics | Unlimited |
| Provider Limitations | Must use participating dentist | Any licensed dentist | Must use DPO participating dentist |
| **Selected Services** | **Some services listed below may be covered subject to deductibles and coinsurance as shown above** | **Some services listed below may be covered subject to deductibles and coinsurance as shown above** | **Services listed below are covered in full subject to copayments as shown below** |
| Examinations | Oral evaluations limited to twice per calendar year<br>Plan pays 100% | Oral evaluations limited to twice per calendar year<br>Plan pays 90% | Oral evaluations limited to twice per calendar year<br>Plan pays 100% |
| X-rays | Covered subject to limitations<br>Plan pays 100% | Covered subject to limitations<br>Plan pays 90% | Covered subject to limitations<br>Plan pays 100% |
| Cleanings (Oral prophlylaxis) | Two cleanings per calendar year Plan pays 100% | Two cleanings per calendar year Plan pays 90% | Two cleanings per calendar year Plan pays 100% |
| Fluoride applications | Covered only for children under age 19 Twice per calendar year Plan pays 100%[1] | Covered only for children under age 19 Twice per calendar year Plan pays 90% | Covered only for children under age 19 Twice per calendar year Plan pays 100%[1] |

[1] In the Dental Expense Plan, you are responsible for the amount the dentist charges above the reasonable and customary allowances.

| | Dental Expense Plan | | Dental Plan Organization (DPO) |
|---|---|---|---|
| | In-Network | Out-of-Network | |
| Tooth sealants | Covered for children under age 19 (with restrictions) Plan pays 100%[1] | Covered for children under age 19 (with restrictions) Plan pays 90% | Covered only for children under age 19 No copayment (limitations apply) |
| Routine fillings | Plan pays 80%[1] | Plan pays 70%[1] | Covered Copayments may apply[2] |
| Simple extraction | Plan pays 80%[1] | Plan pays 70%[1] | Covered after copayment of $20 |
| Crowns | Plan pays 65%[1] | Plan pays 55%[1] | Covered after copayment of $150-$225[2] |
| Root Canal (Endodontics) | Plan pays 80%[1] | Plan pays 70%[1] | Endodontic Therapy covered after copayment of $100-$175 |
| Dentures | Repair of existing dentures covered at 80%[1] New or replacement dentures covered at 50% | Repair of existing dentures covered at 70%[1]New or replacement dentures covered at 40% | Covered after copayment (with limitations)[2] |
| Oral surgery for removal of impacted tooth | Plan pays 80%[1] Considered under the medical plan first then dental will consider | Plan pays 70%[1] May be covered under the medical plan first then dental will consider | Covered under copayment of $65 |
| Periodontics | Plan pays 50% (with limitations) | Plan pays 40% (with limitations) | Covered after copayment of: $30 for gingivectomy (one to three teeth) $55 for root planning (per quadrant) $100-$175 for osseous surgery |
| Orthodontic | After you have been employed for 10 months, eligible services covered at a 50% coinsurance level, up to a $1,000 lifetime maximum per child Covered only for those who start treatment before age 19 (See the *Employee Dental Plans Member Handbook* for specifics) | After you have been employed for 10 months, eligible services covered at a 40% coinsurance level, up to a $750 lifetime maximum (maximum of $1,000 combined in and out-of-network) per child Covered only for those who start treatment before age 19 (See the *Employee Dental Plans Member Handbook* for specifics) | Maximum treatment is 24 months Copayment as follows:<br>Patient under age 18: After copayment of $1,000 or 50% of bill whichever is less<br>Patient age 18 or over: After copayment of $1,750 or 50% of bill whichever is less |

[1] In the Dental Expense Plan, you are responsible for the amount the dentist charges above the reasonable and customary allowances.

[2] See the Employee Dental Plans Member Handbook for DPO copayment amounts.